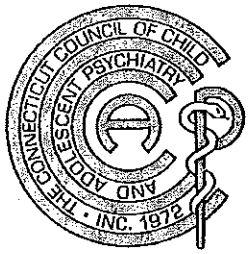


Connecticut Council of Child and Adolescent Psychiatry
Yale University Child Study Center

March 6, 2014

From: Laine Taylor, D.O., M.B.A.- representing Connecticut Council on Child and Adolescent Psychiatry and Yale University Child Study Center

To: Members of the Insurance and Real Estate Committee

Thank you for hearing our testimony regarding SB 202 regarding insurance coverage of telemedicine services. My name is Dr. Laine Taylor and I am here representing two organizations; the Connecticut Council of Child and Adolescent Psychiatry and Yale University Child Study Center. As a physician, advocate for children and families, and a constituent, I thank you for considering this bill introduced by Senator Crisco.

Telemedicine is a treatment modality that has been used for decades within healthcare for the delivery of direct patient care and for consultation between specialties. Many of my colleagues and I have had experience in this medium in the delivery of psychiatric services. We speak to you today in support of HB 202.

Telemedicine allows access to medical care to the underserved populations of the rural and urban areas of Connecticut. It assists in closing the medical access gap within Connecticut for those with insurance by making highly skilled medical professionals available to individuals who would otherwise be excluded from care due to their location within the state. As a Child and Adolescent Psychiatrist, I have first hand experience with the barriers to care for my patients. Many families travel long distances to be seen by a child psychiatrist or to receive the recommended level of outpatient care. This is a fact becoming more evident to members of our state government as evidenced by legislative and executive efforts over the last 2 years to expand mental health services access for children, adolescents, and their families. Thank you for all of your hard work. We ask

that this bill be considered a part of those efforts.

CCCAP and Yale Child Study Center support legislation which would initially narrow reimbursement to telepsychiatry as a pilot for the future application to other medical specialties. There is great evidence in support of telepsychiatry increasing access, reducing medical costs and having equivalent efficacy to face-to-face interventions. We recommend that telepsychiatry be considered to establish rates in conjunction with other access legislation already enacted to law. Specifically, PA 13-3 and PA 13-178 were developed to address the access gap for the children of Connecticut. We believe that the inclusion of SB 202 will enhance care. Telemedicine will increase the availability of Child Psychiatrists and other psychiatric specialties to families and children in the rural and urban areas of our state. In addition to enhancing our state laws, this telemedicine bill as it pertains to psychiatry, helps the state reach the goals of access and reimbursement parity as discussed in the Mental Health and Addictions Parity Act of 2010.

The Council has evaluated several active pilot programs in telepsychiatry, including those funded by Value Options of Connecticut at the Yale Child Study Center. To this point, the pilot programs have shown great utility in increasing access for patients to child psychiatrists. Additionally, the programs have improved coordination of care and facilitated consultation between primary care clinicians and child and adolescent psychiatrists. We believe that setting rates equivalent to face-to-face reimbursement would promote the use of this medium for healthcare delivery and increase the enrollment of child psychiatrists to private insurance panels.

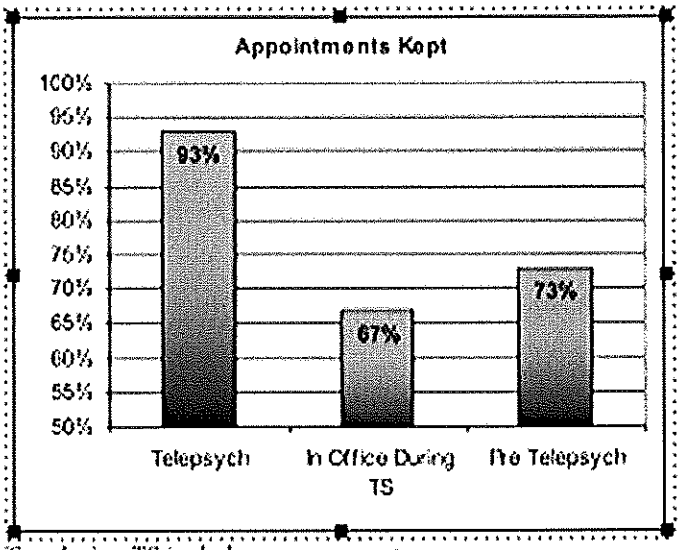
The Connecticut Council on Child and Adolescent Psychiatry and Yale University Child Study Center recommend the following adjustments to SB 202:

1) We recommend this be considered as a bill to address telepsychiatry with future plans to expand this medium for all medical specialties. This could serve as a pilot in which quantitative and qualitative data on access, utilization, and quality of care could be obtained. There is such data available in many other states, but this would allow for the evaluation of efficacy specific to our states populations and regions.
2) We would like to specifically request that the definition of telemedicine not include audio use of telephone or facsimile. This is important as we consider this modality for equivalent rates to face-to-face medical visits.
3) We recommend that the bill language require that physicians practicing telepsychiatry in Connecticut have a Connecticut Medical License.

Thank you for your time and consideration of our recommendations and for considering HB 202.

HB 202: Telepsychiatry data

Results from Greene County Telemedicine Pilot Project. Greene County, PA 2009



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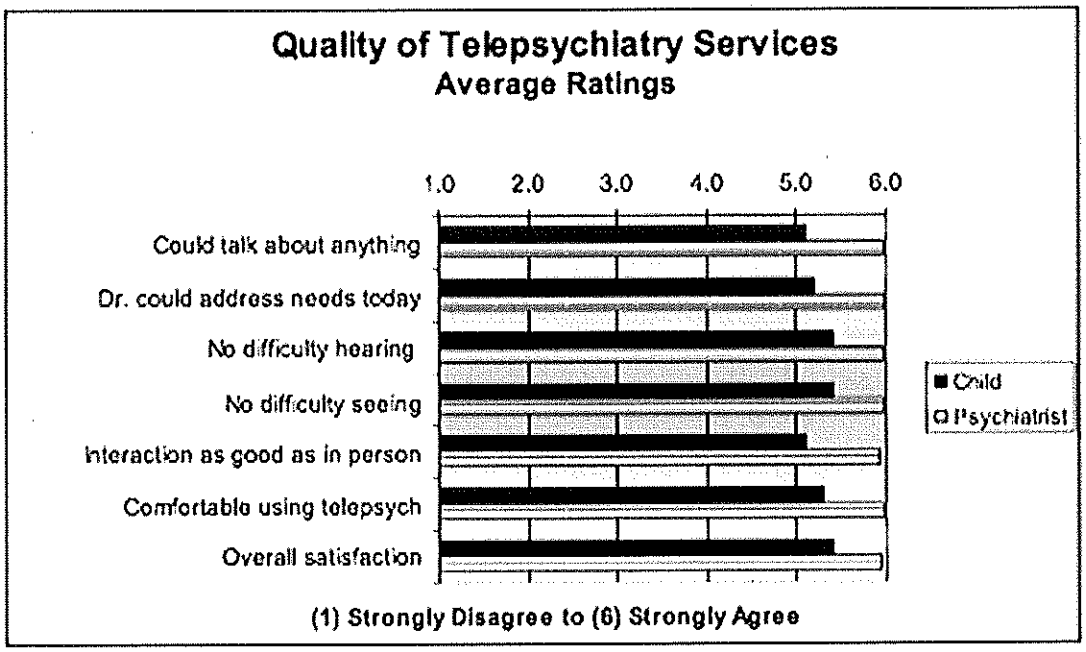

Agreement Between Telepsychiatry Assessment and Face-to-face Assessment for Emergency Department Patients

J Telemed Telecare published online 10 January 2014

Richard W Seidel and Mark D Kilgus

Seidel and Kilgus

Table 1. Agreement between two psychiatrists. The interviewing psychiatrist used telemedicine or face-to-face assessment; the observer was face-to-face.

	Face to face	95% CI	Telepsychiatry	95% CI	*P*-value
Disposition	$k = 0.18$	−0.21, 0.58	$k = 0.37$	−0.08, 0.81	0.55
Disposition Rating Scale	$k = 0.28$	0.09, 0.47	$k = 0.46$	0.31, 0.62	0.15
HCR-20 Final Risk Judgment	$k = 0.30$	0.02, 0.58	$k = 0.45$	0.21, 0.70	0.43
Diagnosis	$k = 0.47$	0.26, 0.69	$k = 0.27$	0.05, 0.48	0.19
SSI total score	ICC = 0.73	0.47, 0.88	ICC = 0.40	−0.02, 0.70	